Manitoba Wheelchair Program
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
Phone (204) 975-3250 Fax (204) 975-3240 Toll Free 1-800-836-5551

MANUAL TILT IN SPACE / RECLINE WHEELCHAIR APPLICATION
CATEGORY 3A/ 3B
PEDIATRIC AND ADULT

Note: Illegible or incomplete application forms will be returned to the prescriber

☐ NEW APPLICATION	☐ EXCHANGE APPLICATION REASON FOR EXCHANGE: _____

DEMOGRAPHICS (PLEASE PRINT)

FIRST NAME		LAST NAME
DATE OF BIRTH (MM/DD/YYYY)	GENDER male female	PHIN
HOME ADDRESS	CITY	POSTAL CODE
HOME PHONE	CELL PHONE	EMAIL
RESIDENCE IS A PCH OR INSTITUTION: ☐ YES ☐ NO		APPLICANT IS PANELED/WILL BE PANELED TO PCH ☐ YES ☐ NO

CURRENTLY IN HOSPITAL? ☐ YES ☐ NO Discharge Date: _____ Discharge Location: _____

Note: Prescribing therapist must inform MWP if there is a change in discharge location (i.e. PCH, Chronic Care)

Delivery Instructions (If different than home address): _____

NEXT OF KIN (MUST BE A MANITOBA RESIDENT)

FIRST NAME	LAST NAME	RELATIONSHIP TO APPLICANT
HOME ADDRESS	CITY	POSTAL CODE
HOME PHONE	CELL PHONE	EMAIL

THIRD PARTY FUNDING INFORMATION (COMPLETE AREAS THAT APPLY)

☐ EMPLOYMENT & INCOME ASSISTANCE

Case Number: _____

☐ NON INSURED HEALTH BENEFITS

☐ NIHB Loan Agreement attached

10-digit number: _____

☐ The prescriber has verified the applicant is not eligible WCB, MPIC, Victim's Services funding and/or is not a ward of Child & Family Services

PRESCRIBER INFORMATION

☐ OCCUPATIONAL THERAPIST	☐ PHYSIOTHERAPIST	☐ OTHER, SPECIFY:
FIRST NAME	LAST NAME	FACILITY NAME
REGISTRATION #	PHONE	FAX
ADDRESS	CITY	POSTAL CODE
SIGNATURE	EMAIL	DATE

MEDICAL DIAGNOSES AND FUNCTIONAL IMPLICATIONS REQUIRING USE OF TILT WHEELCHAIR

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ELIGBILITY CRITERIA – THERAPIST CONFIRMS THE FOLLOWING CONDITIONS APPLY

☐ **REQUIREMENT:** Applicant is a full time user (6+ hours per day)

☐ **REQUIREMENT:** Non ambulatory

☐ **REQUIREMENT:** Home has an accessible entrance: *(circle one)* street level entrance ramp platform lift
Verified by: _____

☐ Applicant has caregiver support to apply tilt at regular intervals throughout the day.

☐ Assessments and equipment trials completed to date support the application of tilt as basic and essential for the applicant

☐ Assessment results reveal the application of tilt is required for the following reasons: *(check all that apply and elaborate below)*

- ☐ **Pressure Management** (e.g. pressure redistribution, wound management)
- ☐ **Postural Support** (e.g. eye gaze, trunk extension, stability in chair)
- ☐ **Functional Optimization** (e.g. improve sitting tolerance, improve posture for feeding/swallowing)
- ☐ **Respiratory Function** (e.g. improve ease of suctioning or vent care, improve breathing/ air exchange)
- ☐ **Other** *(justification included below)*_____

☐ Applicant has been informed the prescribed wheelchair will not collapse for transport

☐ Applicant has been informed that the Manitoba Wheelchair Program will not supply a backrest or cushion for the prescribed chair.

PRESCRIPTION – MWP RESERVES THE RIGHT TO SELECT A CHAIR BASED ON INVENTORY LEVELS

☐ **Ped: Zippie Iris**	☐ **3A: Quickie SR45 (265 lbs.)**	☐ **3A: Quickie Iris (300lbs)**

☐ **ORDER FORM FOR SELECTED TILT IN SPACE WHEELCHAIR ATTACHED**

RATIONALE FOR WHEELCHAIR SELECTION: *(MUST BE COMPLETED)*

PRESSURE MANAGEMENT AND SKIN INTEGRITY EVALUATION

CURRENT SKIN INTEGRITY

☐ **INTACT** ☐ **HISTORY OF BREAKDOWN** ☐ **PRESSURE INJURY**	**Describe:**

CURRENT PRESSURE MANAGEMENT STRATEGIES

CAN THE APPLICANT <u>EFFECTIVELY</u> REPOSITION FOR THE PURPOSE OF PRESSURE MANAGEMENT (I.E. OFFLOADING)?
Describe:

IF APPLICANT IS UNABLE TO EFFECTIVELY REPOSITION FOR THE PURPOSE OF PRESSURE MANAGEMENT, WHAT ALTERNATE STRATEGIES HAS THE APPLICANT/CAREGIVER INCORPORATED TO ADDRESS PRESSURE MANAGEMENT CONCERNS?

DOES THE APPLICANT AND/OR THEIR CAREGIVERS PERFORM REGULAR SKIN CHECKS?
Describe:

Manitoba Possible.

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POSTURAL EVALUATION

DESCRIBE APPLICANT'S CURRENT SEATING SYSTEM AND RESTING POSTURE *(include wheelchair frame style, seating components and include description of any notable asymmetries at the hips, knees, trunk, head/neck)*

DESCRIBE RANGE OF MOTION LIMITATIONS AND/OR MUSCLE TONE CURRENTLY AFFECTING APPLICANT'S POSTURE IN SITTING:

HIP ROM R: _____ L: _____	**KNEE ROM R: _____ L: _____**	**ANKLE ROM R: _____ L: _____**

DESCRIBE HOW THE USE OF TILT WILL IMPROVE APPLICANT'S POSTURE IN SITTING AND/OR WHY STATIC SEATING ALONE DOES NOT ADEQUATELY ADDRESS THE POSTURAL CONCERNS OUTLINED ABOVE:

FUNCTIONAL STATUS

TRANSFER STATUS	☐ **Independent**	☐ **With Assistance**	☐ **Mechanical Lift**
PROPULSION STATUS	☐ **Independent**	☐ **Partially Independent**	☐ **Attendant Assist**
PROPULSION METHOD	☐ **Arms Only**	☐ **Feet Only**	☐ **Both**
SITTING TOLERANCE	**Total Sit time currently tolerated: _____**		**Desired Sit Time: _____**

DESCRIBE FACTORS THAT LIMIT APPLICANT'S SIT TIME:

DESCRIBE HOW THE USE OF TILT WILL ENHANCE APPLICANT'S FUNCTION

RESPIRATORY STATUS

DESCRIBE HOW THE USE OF TILT WILL IMPROVE APPLICANT'S AIR EXCHANGE/ RESPIRATORY STATUS:
(Include Objective Data if available)

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APPLICANT MEASUREMENTS – INFORMATION PROVIDED MUST REFLECT CURRENT MEASUREMENTS

CURRENT WEIGHT: _____ lbs/ kg (circle one)	HEIGHT: _____ ft. in./ cm (circle one)	
	Measurement (inches)	**Recommended Wheelchair Dimensions (inches)**
HIP WIDTH: (straight line) or widest part of body in sitting		**SEAT WIDTH:**
THIGH LENGTH: (straight line) from back of buttocks to back of knee		**SEAT DEPTH:**
LOWER LEG LENGTH: (straight line) from back of knee to bottom of heel		**SEAT TO FLOOR HEIGHT:**
BACK HEIGHT: Sitting surface to axilla		**BACK HEIGHT:**

APPLICANT MEASUREMENTS – RANGE OF MOTION (ROM) AVAILABLE FOR SEATING

HIP ROM R: _____ L: _____	KNEE ROM R: _____ L: _____	ANKLE ROM R: _____ L: _____

WHEELCHAIR FEATURES

ARMRESTS	LEG RESTS	FOOTPLATES	BACK CANES	ANTI-TIPPERS	WHEEL LOCK EXTENSIONS	HEADREST
☐ Single Post, height adjustable ☐ Standard ☐ Low ☐ Dual Post ☐ height adjustable ☐ flip back	☐ 60 degree ☐ 70 degree ☐ 80 degree ☐ 90 degree ☐ Contracture System* ☐ Elevating*	☐ Composite ☐ Angle adjustable* ☐ Aluminum* *(*only on ELR)*	☐ Fixed Height ☐ Height adjustable ☐ Reclining*	☐ No* ☐ Yes	☐ No ☐ Yes ☐ Right ☐ Left	☐ No* ☐ Yes
ARMPAD ☐ Desk Length ☐ Full Length	Set leg rest length to: (inches) _____					

JUSTIFICATION FOR ANY ITEMS ABOVE MARKED "J" ON THE ORDER FORM OR WITH AN ASTERISK ABOVE:

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **The applicant is aware that the Manitoba Wheelchair Program will only provide ONE mobility device per client.**

☐ **I have reviewed the Equipment Loan Agreement with the Applicant and/or Representative**

Prescriber's Signature _____ **Date** _____

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EQUIPMENT LOAN AGREEMENT

The equipment is the property of Winnipeg Regional Health Authority (WRHA) Manitoba Wheelchair Program as operated by Manitoba Possible.

1. I am entitled to use the equipment while I am a full time resident of Manitoba. If I move outside of Manitoba, I will return the equipment before leaving the province or purchase the equipment.
2. If I move within Manitoba, I will promptly report my new address and telephone number to the Manitoba Wheelchair Program.
3. I will only use the equipment for my personal mobility.
4. I will not sell, loan or allow any other person to use the equipment.
5. I will store the equipment in a secure, heated and dry indoor space to avoid damage or loss. If the equipment is damaged or lost because of failure to comply with safe storage, I will be required to pay the cost of repair or replacement.
6. I am responsible to use the equipment with reasonable care, keep it clean and regularly maintained. If the equipment is damaged or lost due to misuse I will be required to pay the cost of repair or replacement. The MB Wheelchair Program recommends that the wheelchair be added to the client's homeowner's / tenant's insurance policy.
7. I will not remove the permanent identification sticker attached to the equipment.
8. I will make the equipment available for servicing as necessary.
9. The Manitoba Wheelchair Program will have no responsibility for equipment repairs outside of Manitoba.
10. If I enter a Personal Care Home in Manitoba, I may continue to use the equipment only if I have been a client of the Manitoba Wheelchair Program for at least 6 months before admission to the Personal Care Home.
11. The Manitoba Wheelchair Program may re-assess my eligibility for the equipment at anytime.
12. I will promptly return the equipment to the Manitoba Wheelchair Program if I a) am no longer eligible under the Manitoba Wheelchair Program OR b) no longer need the equipment OR c) fail to observe the terms of this agreement. I recognize that taking care of the equipment and returning it when I no longer need it will benefit other people. If the equipment is not returned, I will pay the depreciated value to replace the equipment.
13. If I am a minor, I agree this is a contract to supply a necessary wheelchair and is binding on me when I reach 18. If I am signing on behalf of a minor, both the minor and I are individually liable for these obligations.

The personal Health Information on this application is treated in compliance with the "Personal Information Protection and Electronic Documents Act." In order to serve you better we may need to share your personal information with others. Most commonly these include medical professionals. Manitoba Possible promises to treat your personal information in a secure and reasonable fashion while providing you with the highest level of professional service.

☐ **I have read and understand the terms of the above Equipment Loan Agreement. I am legally bound by the terms and accept the loan of the equipment on these terms.**

☐ **I authorize the Manitoba Wheelchair Program and/or Manitoba Possible to disclose my personal health information contained in my wheelchair application to authorized personnel for the sole purpose of processing my wheelchair request**

Client Signature: _____ Date: _____

If client cannot write, a **LEGAL REPRESENTATIVE** may sign on behalf of the client below:

Name: _____ Signature: _____ Relationship to Client: _____

Witness Name: _____ Witness Signature: _____